Step-by-Step Instructions for Completing The Dental Claim Form, 2006 Version For MaineCare Covered Services

Introduction

Please follow these instructions for completing your Dental Claim Form.

The Dental Claim Form 2006 is a standard form approved by the American Dental Association

You are responsible for obtaining your own forms; the Maine Department of Health and Human Services (DHHS) does not provide them. You can buy the forms at office supply centers and from other business and medical form suppliers.

Submit only claim forms. Do not submit pre-treatment estimate requests or prior authorization requests with your dental claim.

Send pre-treatment estimate requests and prior authorization requests to:

Prior Authorization Unit
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME 04333

Or Fax to 207-287-7643

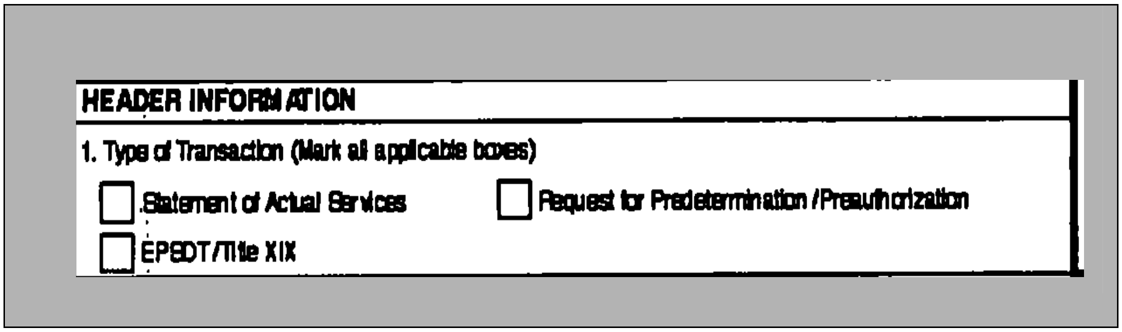
Mail your completed Dental Claim Form including adjustment and void claims to:

MaineCare Claims Processing
M-600
Augusta, ME 04333

Required and Not required. Boxes and Fields (EXAMPLE)

In the following step-by-step instructions for the Dental Claim Form, boxes and fields that are **Not required** are shaded. All required boxes and fields are clear.

Not required:

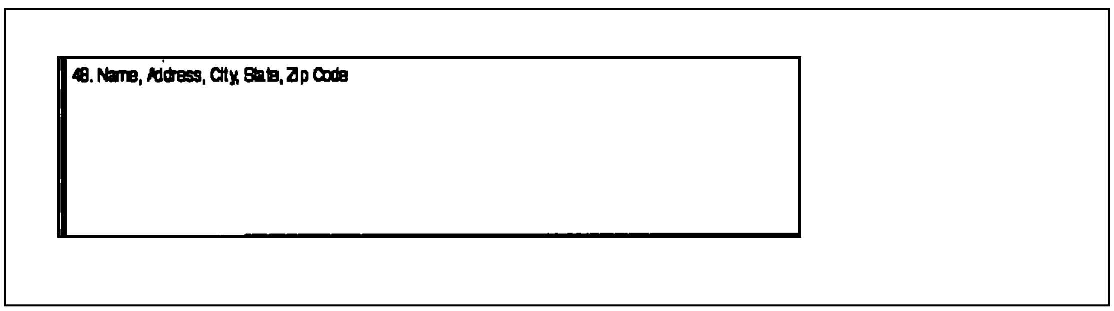

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination /Preauthorization

☐ EPSDT/Title XIX

Required:


48. Name, Address, City, State, Zip Code

Please note, although some boxes are **Not required.**, they are also not shaded. This is because DHHS recommends that you enter special information in these boxes.

Examples and Additional Help

The instructions for each required box or field include an example of what the completed box or field should look like. In some boxes that have special instructions for specific providers, there are additional examples.

The instructions also give you important information and help.

Look for these icons:

ALERT:

TIP:

Additional Tips on Filing

Here is other important information you need to know before you begin filling out your form:

- Use current American Dental Association (ADA)-approved codes for dental procedures from the Current Dental Terminology Manual (CDT).
- Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which you bill. You may access these codes at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm
- Whether you fill in your claim form by typing, computer, or handwriting, keep all information within the designated boxes. Do not overlap information into other fields.

Instructions for All Boxes and Fields on The ADA Dental Claim Form 2006 version

Boxes 1 – 2

BOX 1: TYPE OF TRANSACTION

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

Not required.

BOX 2: PRIOR AUTHORIZATION

2. Predetermination/Preauthorization Number

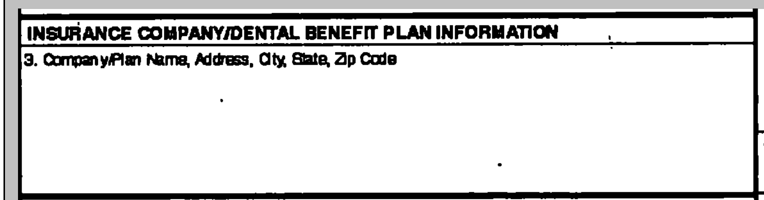
If the Office of MaineCare Services or another agency issued prior authorization for this procedure, enter the Prior Authorization number.

Do not submit a prior authorization letter or form with this claim.

If this procedure does not need prior authorization, leave this box blank.

Boxes 3 – 7

BOX 3: INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION


INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

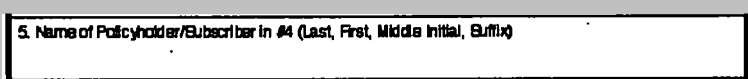
Not required

BOX 4: OTHER COVERAGE


4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

Not required

BOX 5: NAME OF POLICYHOLDER/SUBSCRIBER


5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

Not required

BOX 6: DATE OF BIRTH


6. Date of Birth (MM/DD/CCYY)

Not required

BOX 7: GENDER


7. Gender
☐ M ☐ F

Not required

BOX 8: POLICYHOLDER/SUBSCRIBER ID (SSN OR ID#)


8. Policyholder/Subscriber ID (SSN or ID#)

Not required

BOX 9: PLAN/GROUP NUMBER

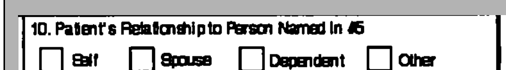

9. Plan/Group Number

Not required

ALERT:

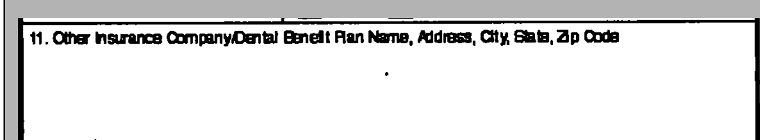
Do not put the patient's account number in this box.

BOX 10: PATIENT'S RELATIONSHIP TO PERSON NAMED IN #5


10. Patient's Relationship to Person Named in #5
☐ Self ☐ Spouse ☐ Dependent ☐ Other

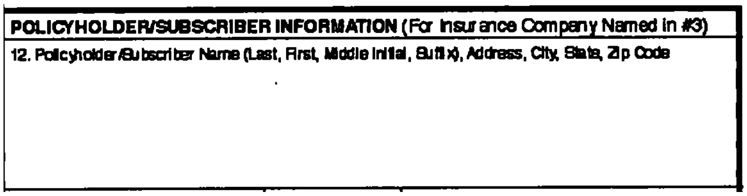
Not required

BOX 11: OTHER INSURANCE COMPANY/DENTAL PLAN


11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

Not required

BOX 12: POLICYHOLDER/SUBSCRIBER NAME


POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

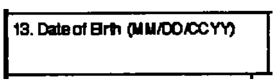
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Enter the member's name **exactly** as it appears on his/her MaineCare eligibility card: last name, first name, and middle initial. Include any punctuation that is in the member's name.

Example: O'Neil, Susan J.(apostrophe becomes a space)

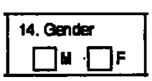
Required

BOX 13: DATE OF BIRTH


13. Date of Birth (MM/DD/CCYY)

Required

BOX 14: GENDER


14. Gender

☐ M ☐ F

Required

Boxes 15 – 18

BOX 15: PATIENT ID

15. Policyholder/Subscriber ID (SSN or ID#)

To verify a patient's MaineCare eligibility, use the medical eligibility swipe card system, or the Interactive Voice Response system (IVR) at 1-800-452-4694 or 207-287-3081.

Required

☞ **TIP:**

Do not use member's social security number.

BOX 16: GROUP/PLAN NUMBER

16. Plan/Group Number

Not required

BOX 17: EMPLOYER NAME

17. Employer Name

Not required

BOX 18: PATIENT INFORMATION

PATIENT INFORMATION

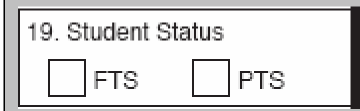
18. Relationship to Policyholder/Subscriber in #12 Above

☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

Not required

Boxes 19 – 21

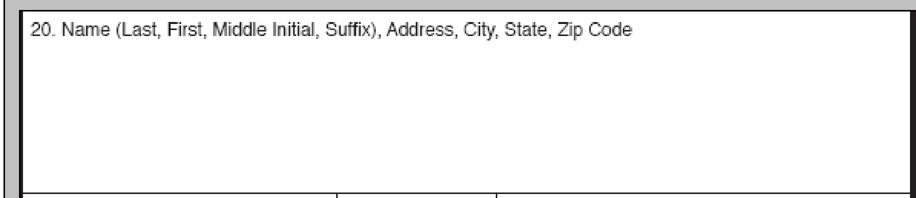
BOX 19: STUDENT STATUS


19. Student Status

FTS PTS

Not required

BOX 20: NAME


20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Not required

BOX 21: DATE OF BIRTH


21. Date of Birth (MM/DD/CCYY)

Enter the month, day, and year the member was born in 8-digit format (MMDDCCYY).

Not required

Box 22: GENDER

22. Gender
M ☐ F ☐

Enter an X in the appropriate M or F Box.

Not required

Box 23: PATIENT ID/ACCOUNT

23. Patient ID/Account # (Assigned by Dentist)

This box is optional. Use this box to enter patient account information, such as the patient's account number or last name. This information will appear on your remittance advice statement (RA).

Optional

RECORD OF SERVICES PROVIDED

BOX 24: PROCEDURE DATE

	24. Procedure Date (MM/DD/CCYY)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Must be 8-digit format. MMDDCCYY

Required

BOX 25: AREA OF ORAL CAVITY

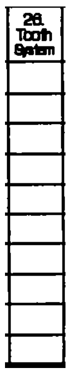
25. Area of Oral Cavity

Use this box to report the area of the oral cavity when the procedure is related to an oral cavity, e.g. periodontal sealing.

Optional

Box
26

BOX 26: TOOTH SYSTEM



Enter number of units.

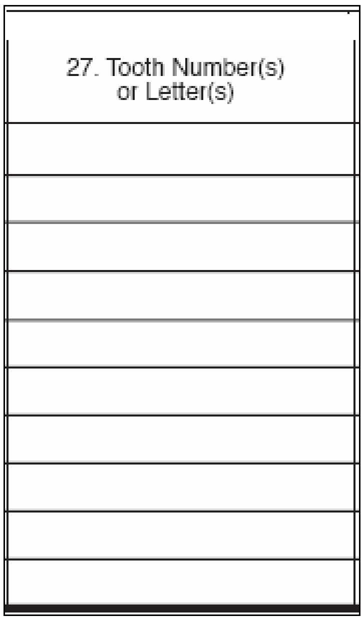
Required

ALERT:

Do not leave this blank. Enter Units.

Not tooth system code

BOX 27: TOOTH NUMBERS OR LETTERS


27. Tooth Number(s) or Letter(s)

Enter the tooth number (1–32 for permanent teeth) or the tooth letter (A–T for primary teeth).

NOTE: For tooth numbers 1–9, **do not put a zero before the tooth number.**

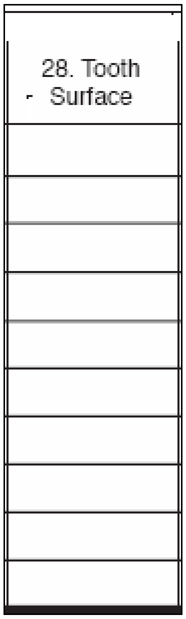
For supernumerary tooth designation, please use the following:

> Permanent dentition: Supernumerary teeth are identified by the numbers 51–82 (add 50 to each tooth number). Example: tooth 32 would be supernumerary tooth 82.

Primary dentition: For supernumerary teeth (A–T), place the letter S after the letter of the primary tooth.
Examples: tooth A would be AS. Tooth Q would be QS

Required if procedure directly involves a tooth

BOX 28: TOOTH SURFACE


28. Tooth Surface

Enter the appropriate letter indicating the surface of the tooth that was restored:

O: occlusal
M: mesial
D: distal
B: buccal
L: lingual
F: facial
I: incisal

Required, if procedure directly involves one or more tooth surfaces (e.g. restorations)

BOX 29: PROCEDURE CODE

29. Procedure Code

Required

BOX 30: DESCRIPTION

Description

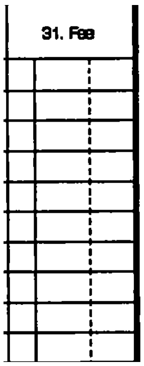
Not required unless using a modifier

☞ **TIP:**

Enter appropriate modifier if required. See Appendix A for modifiers.

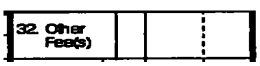
When using a modifier it must be left justified.

BOX 31: FEE



Required

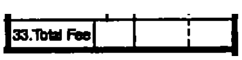
BOX 32: OTHER FEE(S)



If billing after other insurance you must attach an EOB. Enter the insurance payment in this field and/or enter spenddown amount here. Attach spenddown letter.

Required

BOX 33: TOTAL FEE



Enter the total of Box 31 minus Box 32

☞ **TIP:**

Enter usual and customary charges unless you have received prior authorization.

Please ensure that the amount of the prior authorization you enter is correct for each unit. This is important if the prior authorization was for more than one unit.

BOX 34: MISSING TEETH INFORMATION

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Not required

BOX 35: REMARKS

35. Remarks

For **adjustments or voids only**. If this is an adjustment or void, and not an original claim, enter the appropriate adjustment code:

7 to replace a previous claim, or

8 to void or to cancel a previous claim.

Also enter the original Transaction Control Number (TCN) in this field.

For assistance with adjustments, please call:

1-800-321-5557, Option 8

Only required if adjusting or voiding a claim

BOX 36: PATIENT/GUARDIAN SIGNATURE AND DATE

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

Patient/Guardian signature Date

Not required

BOX 37: SUBSCRIBER SIGNATURE AND DATE

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X

Subscriber signature Date

Not required

BOX 38: PLACE OF TREATMENT

38. Place of Treatment

☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

Enter an X in the appropriate box for the place of treatment.

Select ECF (Extended Care Facility) if the service was in a Nursing Facility, Boarding Home, ICF/MR, Adult Family Home, or Private Non-Medical Institution.

Required

BOX 39: NUMBER OF ENCLOSURES

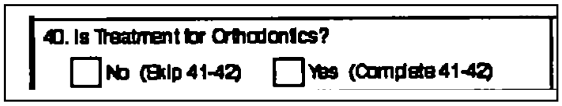
39. Number of Enclosures (00 to 99)

Radiograph(s) Oral Image(s) Model(s)

Not required

Boxes 40 - 44

BOX 40: TREATMENT FOR ORTHODONTICS?


40. Is Treatment for Orthodontics?
No (Skip 41-42) Yes (Complete 41-42)

Enter an X in the **Yes** or **No** checkbox. If Yes, also complete these fields:

BOX 41: DATE OF APPLIANCE PLACED

Enter the month, day and year the appliance was placed in 8-digit format MMDDYYYY.

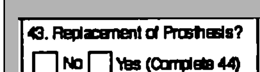
Required

BOX 42: MONTHS OF TREATMENT REMAINING


42. Months of Treatment Remaining

Enter the number of months of treatment remaining MMDDYYYY.

BOX 43: REPLACEMENT OF PROTHESIS


43. Replacement of Prosthesis?
No Yes (Complete 44)

Not required

BOX 44: DATE PRIOR PLACEMENT


44. Date Prior Placement (MM/DD/CCYY)

Not required

BOX 45: TREATMENT RESULTING FROM

45. Treatment Resulting from
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

Enter an X in the appropriate **Yes** or **No** checkbox. If Yes is checked, complete the *Brief description and dates* field. Give a short description of the illness or injury, followed by the date of the illness or injury using 8-digit format (MMDDYYYY).

If Applicable

BOX 46: DATE OF ACCIDENT

46. Date of Accident (MM/DD/CCYY)

If Applicable

BOX 47: AUTO ACCIDENT DATE

47. Auto Accident State

If Applicable

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

BOX 48: NAME
ADDRESS
CITY, STATE, ZIP CODE

Required

BOX 49: NPI

49. NPI

Not required

BOX 50: LICENSE NUMBER

50. License Number

Enter the license number of the dentist or other dental professional who provided the service. **Not required,** but recommended.

Optional

BOX 51: SSN OR TIN

51. SSN or TIN

Optional

BOX 52: PHONE NUMBER

52. Phone Number ( ) -

Not required, but recommended

BOX 52A: ADDITIONAL PROVIDER ID

52A. Additional Provider ID

Enter the Billing Provider's nine-digit Billing Provider ID number assigned by MaineCare.

Required

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

BOX 53: TREATING DENTIST SIGNATURE AND DATE

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

Enter the provider's name. The signature may be typed or stamped. An authorized person may sign on behalf of the treating dentist. The name must be the name of an actual person.

Do not use "signature on file."

Enter the month, day and year this claim form was completed using 8-digit (MMDDYYYY).

Required

BOX 54: NPI

54. NPI

Not required

BOX 55: LICENSE NUMBER

55. License Number

Enter the license number of the dentist or other dental professional who provided the service.

OPTIONAL

BOX 56: ADDRESS, CITY, STATE, ZIP CODE

56. Address, City, State, Zip Code

Not required

BOX 56A: PROVIDER SPECIALTY CODE

56A. Provider Specialty Code

Not required

BOX 57: PHONE NUMBER

57. Phone Number ( ) -

Not required

Box
58

BOX 58: ADDITIONAL PROVIDER ID#

58. Additional Provider ID

Enter the Servicing Provider ID number for the dentist, hygienist or denturist who performed the service. Refer to your MaineCare enrollment letter for Servicing Provider ID numbers. Servicing Provider numbers always end in 99.

A hygienist working in a dentist's office does not require a Servicing Provider ID number. However, any other hygienist, such as those under public health supervision, must enroll as a Servicing Provider and obtain a Servicing Provider ID number.

Required if you have been assigned an Servicing Provider ID

ALERT:

If you have not been assigned a Servicing Provider ID number, leave this field blank.

Do not put your NPI number in this field.

APPENDIX A

MODIFIERS

Compliance with the Health Insurance Portability and Accessibility Act may require changes to the modifiers listed below. Providers will be notified of any changes by regular mail in the form of billing instructions.

A modifier provides the means whereby the reporting dentist can indicate that a service, which has been performed, has been altered by some specific circumstance, but not changed in its definition or code. Modifiers indicate situations such as:

1. A procedure was performed by more than one dentist.

2. A bilateral procedure was performed.

3. Unusual events occurred that made the procedure much more difficult or time consuming.

MaineCare will only accept the two-character modifiers listed on the following pages.

Some modifiers are meant to affect the fee payable for a particular service. These are called pricing modifiers. For example, the modifier used to indicate a surgical assist will allow payment of a percentage of the fee paid to the primary surgeon

Other modifiers do not affect the pricing of a particular code but they do describe more accurately the service being provided. These are called descriptive modifiers. For example, there is a modifier that identifies a service as a repeated procedure. This modifier more accurately defines the service but does not affect the level of reimbursement for the service.

MaineCare is able to accept up to two modifiers per code. It is believed that, in almost all circumstances, providers will be able to accurately describe a service by the use of the appropriate procedure code and up to two modifiers. When it is necessary to use more than two modifiers to accurately define a service. In those instances, you are directed to use modifier "99", which indicates multiple modifiers. The use of modifier "99" will result in a manual review of the claim. This will delay payment since the automated processing of the claim will be interrupted. Providers are urged to reserve the use of modifier "99" for those situations in which a service can be properly reimbursed only by the use of three or more modifiers.

It should be noted that modifiers would only be used on a regular basis by oral surgeons. The general dental codes are specific enough to describe most treatments without the use of modifiers.

LIST OF ACCEPTED MAINECARE MODIFIERS FOR DENTISTRY

MODIFIER DEFINITION

22 UNUSUAL SERVICE - The service provided is greater than that usually required for the listed procedure. A report will be required.

ADDITIONAL NOTES:

Modifier 22 must be used with D0150 when billing for the Supplemental Payment to General Dental Providers for Accepting New MaineCare Patients - See Chapter II, Section 25 of the MaineCare Benefits Manual for additional information and billing requirements for the supplemental payment. A report is not required.

50 BILATERAL PROCEDURES - Some bilateral procedures are identified by distinct procedure codes. For those which are not, modifier "50" should be used to designate bilateral procedures which require a separate incision and which are performed at the same operative session. The first procedure is identified by the proper five-digit code; the second (bilateral) procedure is identified by the proper code, plus modifier "50." Incidental procedures should not be billed as bilateral procedures; use this modifier only when the second procedure adds significant time or complexity to the patient's care.

51 MULTIPLE PROCEDURES - When multiple procedures are performed at the same operative session, the major procedure should be identified by the appropriate code. The lesser procedure(s) should be reported by adding the modifier "51" to the appropriate procedure code. Incidental procedures should not be billed as multiple procedures; use this modifier only when the secondary procedure(s) adds significant time or complexity to the patient's care.

55 POST-OPERATIVE MANAGEMENT - Use this modifier to identify the need for post-operative services in addition to routine follow-up care. Post-surgical complications such as infection or relapse or a condition arising, which is unrelated to the surgery, are examples of when it is appropriate to bill for post-operative services.

56 PRE-OPERATIVE MANAGEMENT - Use this modifier to identify situations when one dentist or physician provides the exam and history at the time of a hospital admission and a second dentist or physician performs the surgery. The modifier should be added to the procedure code for the hospital admission. Group practice dentists are considered to be one dentist.

MODIFIER DEFINITION

62	TWO SURGEONS - Use this modifier to identify circumstances when two surgeons (usually with different skills) participate in the management of a particular surgical procedure. Modifier "62" should be added to each of the surgeon's procedure codes.
66	SURGICAL TEAM - Use this modifier to identify circumstances where highly complex procedures require the concomitant services of several surgeons. Each surgeon should add modifier "66" to the procedure codes used for reporting the services. Modifier "66" requires a special report to accompany the claim.
80	ASSISTANT SURGEON - Use this modifier to identify surgical assistant services at a major surgical procedure.
99	MULTIPLE MODIFIERS - Under certain circumstances three or more modifiers may be necessary to completely define a service. In such situations, modifier "99" should be added to the basic procedure and the applicable individual modifiers represented by "99" should be listed as a part of the written description of the service. Claims requiring modifier "99" must include a report.
76	REPEAT PROCEDURE - SAME DENTIST - Use this modifier to indicate that a service was repeated subsequent to the original procedure.
77	REPEAT PROCEDURE - ANOTHER DENTIST - Use this modifier to indicate that a procedure done by another dentist had to be repeated.
81	MINIMUM ASSISTANT SURGEON - Use this modifier to identify minimum surgical assistant services. Use this modifier in addition to modifier "80”.